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be maintained from January 1, 1991 to December 31, 1993. Compliance with these criteria shall be subject to audit.

(2) If a general hospital provides obstetrical care and services, it must agree to participate in a program approved by the department for the provision of prenatal care to persons eligible for medical assistance or medically indigent persons if requested by such a program. The participation of hospitals in an approved program shall include, but not be limited to:

(i) arrangements with designated prenatal care providers, as defined in chapter 822 of the Laws of 1987, for prebooking pregnant women for approximate delivery time, and provision of staff and facilities for the delivery and provision of necessary postpartum care for woman and infants involved in such programs;

(ii) a system for medical record transfer from a prenatal care provider to hospital staff participating in delivery and for the transfer of information regarding hospital delivery and care back to the prenatal care provider for postpartum follow-up; and

(iii) an agreement with designated prenatal care providers, as defined in chapter 822 of the Laws of 1987, to accept the care of high risk patients on a referral basis and/or to provide special tests and procedures which are not ordinarily available to prenatal care clinics if such hospital is capable of caring for high risk patients and/or providing special tests and procedures.

(3) The hospital must be in compliance with the bad debt and charity care reporting requirements described in subdivision (g) of this section.

(d) Payments. The sum of the statewide resources and financially distressed resources as defined in subdivision (b) of this section and payments to financially

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distressed hospitals in accordance with paragraph (4) of this subdivision shall be Medicaid disproportionate share payments. Such funds shall be distributed in accordance with the follcwinq methcdology and sequence:

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(1) For rate years commencing January 1, 1991 and thereafter, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.

(2) The balance of the statewide resources after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision shall be distributed to voluntary sector hospitals on the basis of each hospital's targeted need share.

(i) Need calculations shall be based on need data for the year 2 years prior to the rate year.

(ii) For the rate periods commencing January 1, 1991 and thereafter, the scale specified in subparagraph (iii) of this paragraph shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year 2 years prior to the rate year and their patient service revenues for the year 2 years prior to the rate year.

(iii) The scale utilized for development of each hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to that Portion of Targeted Need
0 - 1%	35%
1+ - 2%	50%
2+ - 3%	65%
3+ - 4%	85%
4+ - 5%	90%
5+	95%

(3) Payments may be adjusted based upon certified corrections of data submitted by hospitals and to reflect maintenance of effort between the voluntary and the major public hospital sectors.

(m) Maintenance of effort. The allocation of resources made available pursuant to paragraphs (1) and (2) may be changed only after an annual review which shall be conducted by the commissioner with respect to general hospitals' bad debt and charity care need as defined in subdivision (b) of this section within each article 43 insurance law or a combined region. For purposes of this review, rate year 1988, 1989, 1990, 1991, 1992 and 1993 need shall be compared to actual rate year 1986, 1987, 1988, 1989, 1990 and 1991 need, respectively. If as a result of the review, there is a finding that there has been a change within the region of at least five percent in the proportional amounts of bad debt and charity care provided by (1) major public general hospitals, and (2) voluntary nonprofit, private proprietary and public general hospitals, other than major public general hospitals, the allocation of resources between these sectors shall be adjusted to reflect this change. The percentage decrease if any, in such care provided by the voluntary sector hospitals, in excess of five percent shall be applied to reduce each of the voluntary hospital's bad debt and charity care pool distributions. Likewise, if there is a proportional decrease in the amount of such care provided by the major public sector hospitals, the percentage decrease if any, in excess of five percent shall be applied to reduce each of the major public hospital's bad debt and charity care pool distributions. The change of five percent shall be measured by subtracting the proportion of total regional need met by a sector in the base year from that sector's proportion in the rate year.

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(4) Financially Distressed Hospitals

(i) Medicaid disproportionate share payments shall be made to financially distressed hospitals to assist in financing losses resulting from bad debts and the costs of charity care. Payments shall be determined after consideration of payments made in accordance with paragraphs (1) and (2) of this subdivision and shall result in up to 100 percent of the hospital's need being financed. For purposes of payments to eligible hospitals, rate year need shall be based on current rate year need data. Such hospitals must request this additional distribution in writing. For each rate year and prior to payment of these funds, financially distressed hospitals shall uniformly account for and report on services provided to patients for which full payment was not received, pursuant to a plan for such uniform accounting and reporting submitted by the hospitals and approved by the commissioner of health.

(ii) Those hospitals that qualified as financially distressed in a rate year but no longer qualify for such status subsequent to the rate year shall receive payments as follows:

(a) two-thirds of the anticipated payment which the hospital would have received had it continued to qualify as financially distressed, shall be paid in the first year in which the hospital does not qualify as financially distressed;

(b) one-third of such anticipated payment shall be paid in the second year the hospital does not qualify as financially distressed; and

(c) no additional distributions shall be available during or after the third year the hospital does not qualify as financially distressed.

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(e) No general hospital shall receive in total from the payments made in accordance with this section an amount which exceeds its need for financing losses from bad debts and the costs of charity care.

(f)(1) The commissioner of health and the commissioner of social services are authorized to contract with article forty-three insurance law plans, or such other administrators as the commissioner of health or commissioner of social services shall designate, to receive and distribute funds designated for disproportionate share payments.

(2) The commissioner of health and commissioner of social services or their designee may allow advanced payments to a financially distressed hospital from the accrued distributive share of such hospital, based on a demonstration by the hospital that there is an inability to finance current obligations and obtain needed working capital.

(g) Monthly bad debt and charity care reports. Hospitals shall file monthly charge reports with the commissioner of health and the commissioner of social services starting in July 1991 for January 1991, and continuing on a monthly basis thereafter, describing, by DRG for inpatient services and by visits for categories of outpatient and emergency services, the services actually delivered in each month to those unable or unwilling to pay, and their charges, excluding

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the revenue associated with referred ambulatory patients. The charges shall be collected for the entire year; reduced to cost, and compared to the amount of bad debt and charity care distributions received by the hospital for such services. This data shall be collected on forms and in a manner prescribed by the commissioner of health.

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